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Lived experience in Italian mental health services: a national survey of peer support and co-production practices

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Abstract

Background Peer support has become a cornerstone of recovery-oriented mental health systems worldwide, with increasing recognition of its value in promoting recovery, empowerment, and inclusion. In Italy, despite a long-standing tradition of community-based care, the integration of peer support services (PSSs) remains fragmented and understudied.

Methods A national cross-sectional online survey was conducted between January and February 2025 targeting all Italian Mental Health Departments (MHDs). The survey explored the presence, organization, and perceived impact of peer support and co-production practices.

Results A total of 61 out of 135 MHDs (45%) responded. Among them, 55.7% reported implementing peer support initiatives, primarily within community-based services. Peer support workers (PSWs) were generally perceived as effective in fostering recovery and reducing stigma. However, major barriers included lack of formal recognition, insufficient funding, and cultural resistance (e.g., reluctance among some professionals to acknowledge experiential knowledge or to integrate non-clinical roles into multidisciplinary teams). Co-production practices were reported by more than half of the MHDs, though they remained largely consultative.

Conclusions Peer support and co-production are emerging within in Italy's mental health system but face substantial structural and cultural barriers. National frameworks and dedicated resources are required to support sustainable implementation and the full integration of experiential knowledge into mental health services.

Keywords Peer support workers, Mental health services, Recovery, Implementation

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Introduction

In recent decades, peer support has emerged as a foundational component of recovery-oriented mental health systems across several countries. Peer support services (PSSs) involve individuals with lived experience of mental illness—commonly referred to as Peer Support Workers (PSWs) or Experts by Experience (EbEs)—providing mentorship, support, and advocacy to others navigating similar challenges. These services are grounded in principles of mutuality, empowerment, and the unique value of experiential knowledge, and are increasingly recognized for their contributions to recovery, social inclusion, and person-centered care [1–3].

Peer Support Services (PSSs) have emerged as a valuable approach to bridge the gap between individuals with mental illness and mental health professionals [4]. Defined as the help and support that people with lived experience of mental illness can offer to one another, PSSs are gaining recognition in mental health systems worldwide [5].

The rise of peer support is linked to a growing understanding of recovery as a personal and subjective experience [6], leading to its integration into statutory services [7]. PSWs bring the perspective of service users into interactive processes at both micro and macro levels within mental health and addiction services [8]. Their integration influences the quality and content of services, fostering innovation and change [9]. PSWs offer support, encouragement, and hope to their peers, based on the belief that those who have overcome psychiatric disabilities can provide valuable assistance [10].

A growing body of international evidence supports the effectiveness of peer support interventions. Studies have shown that peer-led services can improve outcomes such as hope, empowerment, quality of life, service engagement, and even reduce hospitalization rates [11–14] Furthermore, the integration of peer workers into mental health teams has been associated with cultural change within services, promoting more egalitarian and recovery-focused practices [15–17].

Recognizing these benefits, several national and international bodies, including the World Health Organization (WHO), have advocated for the formal inclusion of peer support within public mental health systems [18, 19].

Despite the increasing evidence base and alignment with recovery-oriented care policies, the widespread implementation of peer support faces limitations due to methodological and implementation issues [20]. Challenges include role clarity, autonomy, and acceptance by non-peer coworkers [21]. Successfully integrating peer support requires addressing these challenges and providing organizational support for peer services [21].

In Italy, the public mental health system—based on the principles of community care and deinstitutionalization following Law 180/1978—has long been considered a global model for rights-based mental health reform [22, 23]. However, despite this progressive legacy, the systematic inclusion of PSSs remains limited and fragmented. While some regions have introduced peer support initiatives—often in collaboration with service user and family associations—there is currently no national framework guiding their development, implementation, or evaluation [24, 25].

To date, little is known about the extent to which PSSs have been adopted and implemented within Italian mental health system. No national mapping has systematically explored how these services are organized, what roles peer workers play, or what factors facilitate or hinder their integration into public mental health care.

This study aims to fill this gap by reporting findings from a national survey of Mental Health Departments (MHDs) across Italy. The objectives were to: (1) describe the current state of peer support implementation; (2) identify enabling factors and barriers; (3) assess regional variability; and (4) highlight promising practices to inform future policy and practice.

Methods

Study design

A cross-sectional online survey was conducted between 15 January–28 February 2025.

Data collection

The research team developed an invitation e-mail containing a study description and a link to the online questionnaire. The e-mail was disseminated by the research team to the directors of all Mental Health Departments (MHDs) across Italy. To maximize the response rate, the research team sent three follow-up reminders, each spaced 14 days apart. Participation in the survey was voluntary and anonymous; responses were used exclusively for research purposes and service improvement. The online questionnaire was hosted on the "Lime Survey" online platform and could be conveniently accessed using a PC, tablet, or smartphone. The collected data were downloaded and managed by responsible data management personnel at the University of Verona who had no means of identifying study participants.

Given the nature of the study—a survey of organizational practices involving no personal or sensitive data and no participation of patients or identifiable individuals—ethical approval was not required in accordance with national and institutional guidelines.

The questionnaire

An ad hoc, self-administered questionnaire was jointly developed by the research team at the Section of Psychiatry of the University of Verona, in collaboration with two active peer support workers based in Verona. The questionnaire, developed in Italian, comprised 28 items covering multiple dimensions related to the use of PSWs in mental health services. These included: (a) service implementation (e.g., whether PSWs were active, how long initiatives had been in place, in which service settings PSWs operated); (b) roles and activities of PSWs (e.g., group facilitation, individual support, participation in training or co-production); (c) training and remuneration arrangements; (d) perceived benefits (e.g., impact on recovery, reduction of stigma, patient satisfaction); (e) challenges and barriers encountered; (f) co-production practices, including users' participation in planning and decision-making; (g) recovery-oriented strategies implemented by the MHD. An English translation of the questionnaire is provided in Supplementary Material S1.

Italian mental health yystem context

Italy's mental health reform, launched by Law 180/1978 (the Basaglia Law), shifted care from institutional settings to a decentralized, community-based model integrated within the National Health Service (NHS). Mental health care is delivered through regional MHDs, each responsible for a defined catchment area and offering a comprehensive range of mental health services to the adult resident population. These include: (a) Community Mental Health Centers (CMHCs), which serve as the core hubs for outpatient care and coordination of treatment plans; (b) Day Centers and Day Hospitals, offering structured rehabilitation and social inclusion activities; (c) Residential facilities, such as therapeutic communities and supported housing for individuals with high support needs; (d) General hospital psychiatric wards, providing acute inpatient care for short-term stays. The Italian mental health system is publicly funded and regionally governed, leading to regional variations in the organization, quality, and availability of services. Regions are responsible for implementing national guidelines, planning mental health services, and allocating resources. This decentralized model allows for local adaptability but has also resulted in significant disparities in service provision and innovation across the country. Despite these challenges, the Italian system remains strongly anchored in principles of deinstitutionalization, community integration and recovery orientation.

Data analysis

Survey responses were collected and compiled in a secure database. Frequency distributions and graphics were used to summarize the data. Analyses were conducted using Microsoft Excel and SPSS (version 29 for Windows).

Results

Response rate and geographic coverage

A total of 61 out of 135 Italian MHDs completed the questionnaire, giving an overall response rate of 45%. Regional coverage varied significantly. The highest response rates were observed in the North-East (63%) and North-West (54%) of the country, while the Central (30%), Southern (40%), and Island regions (18%) showed lower levels of participation (for details see the on-line Supplement Table S1).

Implementation of peer support initiatives

Among the 61 responding MHDs, 55.7% ($n = 34$) reported having implemented peer support initiatives. Of these, the majority (52.9%) had introduced PSWs within the previous 1–3 years, while 38.2% had been operating such programs for seven years or more. Nearly all participating MHDs (97.1%) reported having at least one PSW, and 67.7% employed four or more.

PSWs were most frequently integrated into Community Mental Health Centers (73.5%) and Day Centers (64.7%), with less common involvement in therapeutic communities (20.6%) and psychiatric inpatient units (17.6%).

Most MHDs (82.4%) reported providing specific training for PSWs before engaging them in service activities. Training was primarily organized internally (64.3%), though regional authorities (35.7%), service user associations (42.9%), and cooperatives (32.1%) also played a role. However, only 35.3% of MHDs reported offering financial compensation to PSWs. Among those that did, the most common funding sources included agreements with social cooperatives (50.0%), MHD-specific funds (25.0%), user associations (33.3%), and, to a lesser extent, direct funding from the Local Health Authority (8.3%).

Importantly, 70% of MHDs lacked formal protocols or guidelines to define PSW roles and responsibilities (Table 1).

The most frequently cited challenges in implementing PSW initiatives included: lack of institutional recognition of the PSW role within the mental health system (52.5%), limited economic resources for training and remuneration (45.9%), cultural resistance (42.6%), lack of clarity on PSW roles and responsibilities within the team (32.8%) and fragmented and limited integration of the PSWs into different services (32.8%).

PSWs were primarily engaged in supporting individual recovery (82.4%), facilitating or co-facilitating group activities (61.8%), and leading peer support groups (44.1%). Their roles included individual accompaniment,

Table 1 Implementation of peer support initiatives ($n=61$)

	n	%
Does your MHD implement peer support initiatives?		
No	23	37.1
Yes	34	55.7
Do not know	4	6.6
How long have these initiatives been active? (27 NA)		
<1 year	3	8.8
1-3 years	18	52.9
4-6 years	0	0
>6 years	13	38.2
How many peer support workers are active in your MHD? (27 NA)		
0	1	2.9
3-Jan	10	29.4
6-Apr	12	35.3
>6	11	32.4
In which MHD services are PSWs employed? (27 NA; multiple choice)		
Community Mental Health Centers	25	73.5
Day Centers	22	64.7
Residential Facilities	7	20.6
Psychiatric Inpatient Units	6	17.6
Do PSWs receive specific training before starting their role? (27 NA)		
Yes	28	82.4
No	6	17.6
Do PSWs in your MHD receive any form of compensation? (27 NA)		
Yes	12	35.3
No	22	64.7
Does your MHD have protocols or guidelines for PSWs' involvement? (27 NA)		
Yes	9	26.5
No	24	70.6
Do not know	1	2.9
Difficulties in integrating peer support workers (*multiple choice*)		
Lack of institutional recognition of the PSW role within the MH	32	52.5
Limited economic resources for training and remuneration	28	45.9
Cultural resistance and prejudice from healthcare professionals	26	42.6
Lack of clarity on PSW roles and responsibilities within the team	20	32.8
Fragmented and limited integration of the PSWSs into services	20	32.8
Difficulty identifying and recruiting suitable PSWs	17	27.9
Lack of specific training for PSWs aligned with MHD needs	15	24.6
Low interest from MHDs in PSW initiatives	12	19.7
Low interest among users in becoming PSWs	11	18
Lack of ongoing supervision and support for PSWs during activities	8	13.1
Difficulty in relationships between PSWs and other professionals	7	11.5
Difficulty in collaboration between PSWs and associations	5	8.2
Low autonomy among MHD users	4	6.6
Resistance from patients to accept PSW support	2	3.3

participation in training activities, and assistance with daily living skills (Fig. 1).

Perceived impact of peer support

Overall, PSWs were perceived as making significant contributions to care. More than 70% of respondents rated their impact on recovery pathways as either "very" (44.1%) or "extremely" (26.5%) effective. Furthermore, 85.3% of MHDs reported that PSWs contributed to reducing stigma and promoting social inclusion, and the same proportion indicated that PSW involvement had improved service user satisfaction (Table 2).

Key mechanisms identified for promoting social inclusion and reducing stigma included the sharing of lived experience and recovery narratives (89.7%), engagement in public awareness initiatives (75.9%), and organizing or participating in cultural and recreational activities (65.5%) (Fig. 2).

Co-production and user involvement

In terms of user involvement in service planning, 57.4% of MHDs assigned a consultative role to users, while only 6.6% reported involving them in actual decision-making. Structured tools such as focus groups or surveys were used to support co-production in 27.9% of cases.

Over half of MHDs (57.4%) reported engaging users in co-production or co-design practices. These practices were most commonly applied to the organization of rehabilitation activities (82.9%), and less frequently to service redesign (28.6%) or staff training (20.0%). Only 14.3% of MHDs rated the level of user participation as high or very high (Table 3).

Reported benefits of co-production included reduced stigma (74.3%), improved relationships between users and providers (65.7%), and more individualized care pathways (65.7%). However, barriers included professional resistance (45.7%), lack of formal guidelines (42.9%), and limited user engagement (25.7%) (Fig. 3).

Recovery-oriented practices

Most MHDs (82.0%) reported implementing strategies to support recovery. The most common practices included individualized care planning (86.0%), collaboration with service user and family associations (78.0%), initiatives to promote social inclusion (76.0%), and provision of educational and occupational support (74.0%). PSWs were explicitly included in recovery-oriented programming in 42.0% of cases.

Among MHDs with peer support or co-production initiatives, 52.9% reported these activities as significantly enhancing recovery pathways, with an additional 14.7% rating their impact as very high (Table 4.).

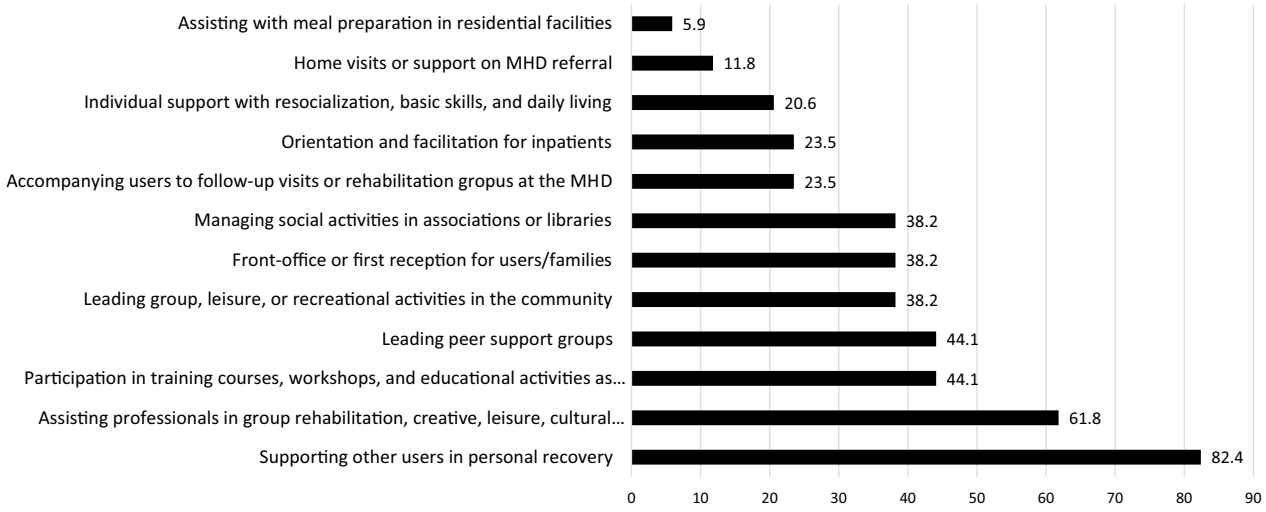

Fig. 1 Main activities carried out by PSWs ($n = 34$ MHDs with implemented initiatives)

Table 2 Usefulness of peer support initiatives ($n = 34$ MHDs with implemented initiatives)

	n	%
Do you consider PSWs effective in improving care pathways?		
Moderately effective	10	29.4
Very effective	15	44.1
Extremely effective	9	26.5
Do PSWs play a role in reducing stigma and promoting social inclusion?		
Yes	29	85.3
No	4	11.8
Do not know	1	2.9
Has PSW involvement improved service users' satisfaction?		
Yes	29	85.3
No	1	2.9
Do not know	4	11.8

Representativeness and potential non-response bias

To assess representativeness, we compared MHDs that responded to the survey ($n = 60$) with those that did not ($n = 71$), using official population figures for each MHD's catchment area (sourced from the Italian National Institute of Statistics [ISTAT] for province-wide authorities; otherwise, the most recent figures from regional or local health authority documents).

National coverage. Participating MHDs collectively covered 30,932,942 residents, compared with 28,880,945 in non-participating MHDs, out of a national denominator of 59,813,887. This corresponds to an overall coverage of 51.7% by respondents.

Macro-area coverage. Coverage by participating MHDs was 64.9% in the North (15,447,944/23,801,451), 48.5% in the Centre (7,651,998/15,762,643), and 38.7% in the South/Islands (7,833,000/20,249,793).

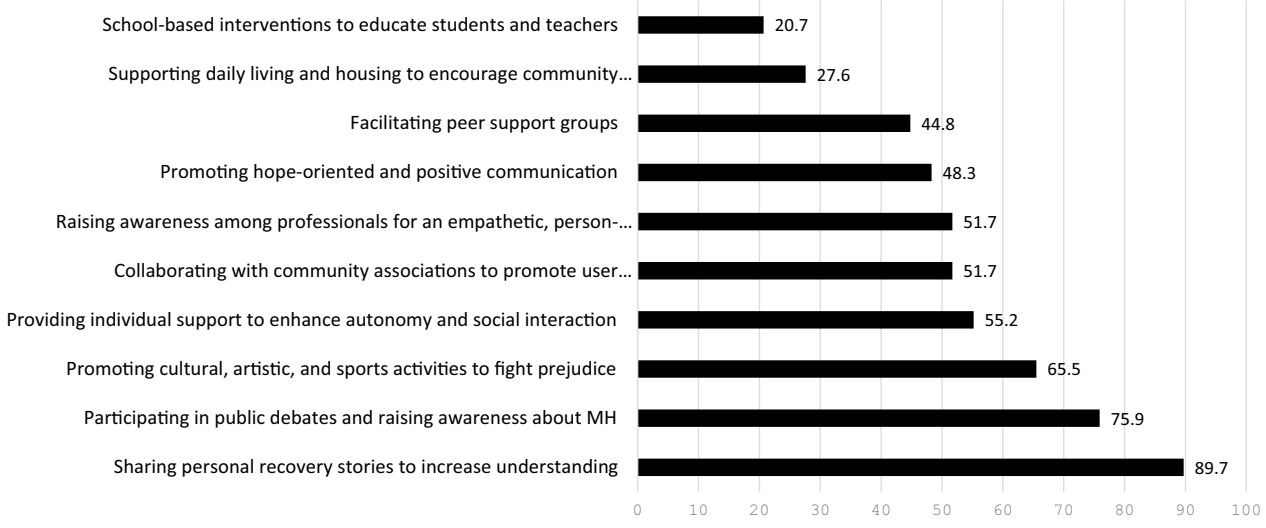

Fig. 2 Contribution of PSWs in reducing stigma and promoting inclusion ($n = 29$ MHDs that declared PSWs playing a role in reducing stigma)

Table 3 Implementation of co-production or co-design initiatives with users ($n = 61$)

	n	%
What role do users have in the strategic planning of your MHD?		
None	21	34.4
Consultative	35	57.4
Decisive	4	6.6
Other	1	1.6
Does your MHD use structured tools (focus groups, questionnaires) to engage users in co-design?		
No	42	68.9
Yes	17	27.9
Do not know	2	3.3
Does your MHD engage in co-production or co-design initiatives with users?		
No	25	41
Yes	35	57.4
Do not know	1	1.6
In which areas does co-production take place? (26 NA; multiple choice)		
Organization of rehabilitation activities	29	82.9
Review of care pathways	12	34.3
Design of new services	10	28.6
Staff training	7	20
To what extent do users actively participate in service design? (26 NA)		
Not at all	2	5.7
A little	16	45.7
Moderately	12	34.3
A lot	3	8.6
Very much	2	5.7

Regional coverage. Coverage varied substantially across regions. Higher coverage was observed in Veneto (80.8%), Trentino-Alto Adige (72.3%), Umbria (69.5%), Piedmont (67.1%), Liguria (64.0%), and Lombardy (60.1%). Lower coverage was recorded in Tuscany (43.9%), Lazio (39.5%), Campania (39.8%), Friuli Venezia Giulia (26.1%), Marche (24.0%), Sardinia (25.5%), and Sicily (30.9%); Basilicata had no participating MHDs.

Catchment area size. Responding MHDs had a larger average catchment (mean 515,549 residents; median 413,020; IQR 322,879–609,562) compared with non-respondents (mean 406,774; median 323,595; IQR 169,072–559,000), indicating a modest tendency for larger MHDs to participate.

Organisational characteristics. All MHDs operate within Italy's National Health Service and are publicly funded. Hospital-only organizations without an exclusive territorial catchment were retained in the lists but excluded from coverage calculations. Beyond this, no systematic differences in organisational model were identified between respondents and non-respondents that could plausibly confound the survey estimates. Further details are provided in on-line Supplementary Tables S2–S5, which report national, macro-area, and regional summaries.

Discussion

This study presents the first national mapping of peer support and co-production practices within Italy's public mental health system. Despite the country's long-standing tradition of community-based, deinstitutionalized care, the integration of lived experience into service delivery remains at an early and uneven stage.

Encouragingly, over half of the responding MHDs reported implementing peer support initiatives, with a recent acceleration in uptake. This is a positive sign that peer support is beginning to be recognized as a legitimate and valuable component of mental health care. PSWs were primarily employed in community-based services such as Community Mental Health Centers and Day Centers, reflecting the enduring strength of Italy's territorial model. Their roles—supporting recovery, co-facilitating groups, and engaging in educational activities—are consistent with international definitions of peer support, emphasizing relational, experiential, and non-clinical contributions to recovery [2, 26].

Nevertheless, the findings reveal structural fragility. Only one-third of MHDs reported offering any form of remuneration for PSWs, and formal protocols regulating their roles and activities were present in less than one-third of cases. These findings suggest a lack of institutional and financial support that risks undermining the sustainability and legitimacy of PSW involvement. These findings echo international literature describing how peer support, while rhetorically endorsed, often lacks consistent funding, role clarity, and professional recognition [27, 28]. The reliance on third-sector organizations and cooperatives for funding and coordination of peer roles is indicative of a hybrid model that risks undermining the institutional integration and sustainability of peer work.

Moreover, the survey revealed notable regional variability in participation, with most responding MHDs located in Northern Italy. This geographical pattern may reflect broader systemic disparities in service development, resource allocation, and - above all - institutional readiness to adopt co-production and recovery-oriented practices. The lower response rates from Southern and Island regions suggest that peer support and co-production initiatives may be less developed or less systematically documented in these areas. This finding underscores the importance of promoting national policies that actively support implementation in underrepresented regions, thereby ensuring that innovations in recovery-oriented care are equitably accessible across the country. At the same time, the lower participation from Southern and Island regions may also reflect methodological factors. Specifically, the survey was conducted by

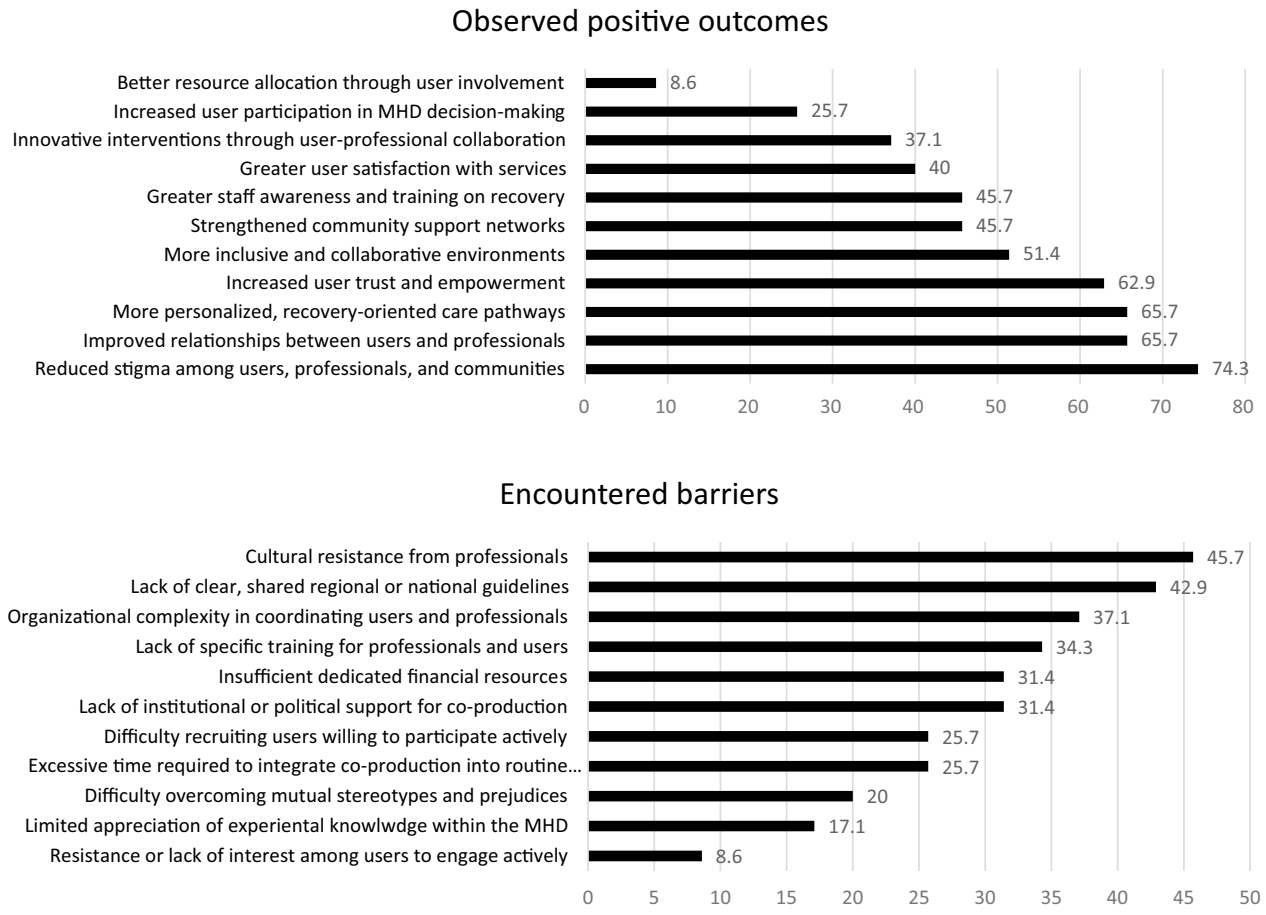

Fig. 3 Co-production: observed positive outcomes (upper graph) and encountered barriers (lower graph) (n = 35 MHDs engaged in co-production or co-design with users)

a single university located in the northeast of the country, rather than by a national health institution, professional body, or scientific society. This circumstance may have reduced engagement from more distant regions, where collaboration or institutional proximity to the Verona research team is weaker.

Despite these challenges, MHDs reported overwhelmingly positive perceptions of PSW contributions—particularly in enhancing recovery processes, improving user satisfaction, and reducing stigma. These findings are consistent with robust evidence internationally that peer support can foster hope, self-efficacy, and social inclusion [3, 11]. Notably, Italian respondents highlighted the power of peer narratives and shared experiences as central mechanisms of change, aligning with research on contact-based anti-stigma interventions [29].

The findings on co-production, while promising, reveal a still-limited level of structural user involvement. Though over half of MHDs reported engaging in co-production or co-design initiatives, this involvement was mostly described as consultative. Only a small proportion of MHDs reported meaningful user participation in strategic planning or service innovation. These results mirror international concerns that co-production often remains tokenistic unless supported by cultural change, shared power, and clear institutional mandates [30, 31].

The survey also identified several systemic and cultural barriers to both peer support and co-production: resistance from professionals, lack of clear guidance, insufficient resources, and limited institutional support. These challenges are not unique to Italy. Across Europe and beyond, studies have shown that the successful implementation of recovery-oriented and participatory practices requires organizational transformation, interprofessional training, and sustained political and managerial commitment [32, 33].

Interestingly, despite the gaps in implementation, a large majority of MHDs reported adopting recovery-oriented strategies such as individualized care plans, social inclusion initiatives, and partnerships with users and family associations. Yet these practices were often not embedded in formal evaluation systems or training curricula. As in other contexts, the adoption of a recovery-oriented language does not always correspond to a

Table 4. Recovery and improvement strategies (n = 61)

	n	%
Does your MHD adopt specific strategies to promote users' personal recovery?		
Yes	50	82
No	10	16.4
Do not know	1	1.6
What are the main actions taken to promote recovery? (11 NA; multiple choice)		
Developing personalized care plans	43	86
Collaboration with users' and families' associations	39	78
Promoting social inclusion	38	76
Educational and occupational support	37	74
Anti-stigma and awareness-raising initiatives	36	72
Educating users about recovery	34	68
Cultural, artistic, and sports activities	34	68
Incorporating recovery principles in staff training	32	64
Home-based recovery-oriented interventions	31	62
Promoting peer support/Self-help groups	26	52
Monitoring recovery progress	23	46
Involving PSWs	21	42
Involving users in co-production	17	34
Strengths-based approach	16	32
To what extent do you think peer support and co-production have contributed to improving recovery pathways? (27 NA)		
Not at all	1	2.9
Moderately	10	29.4
Very	18	52.9
Extremely	5	14.7

transformation in professional culture or service delivery models [34].

Implications for policy and practice and international relevance

To strengthen peer support and co-production in the Italian system, national and regional health authorities should consider developing shared frameworks for the recruitment, training, supervision, and remuneration of PSWs. In addition, formalizing co-production processes—through structured tools, evaluation systems, and guidelines—could help move from isolated initiatives to systemic practice. Investing in staff training and fostering organizational cultures that value experiential knowledge are also key to sustaining meaningful user involvement [35].

While grounded in the Italian context, the findings of this study are highly relevant for other countries seeking to integrate lived experience into public mental health systems. Italy's decentralized and community-based mental health model provides a unique case study of how peer support and co-production can be developed within a publicly funded, rights-based system. The challenges identified—lack of formal recognition, limited funding, cultural resistance (e.g., reluctance among some healthcare professionals to acknowledge the value of experiential knowledge, scepticism toward the integration of non-clinical roles into multidisciplinary teams, and entrenched hierarchical attitudes that limit the acceptance and full utilisation of peer workers) and fragmented implementation—are echoed across various international settings. At the same time, the positive impacts reported by MHDs—particularly in reducing stigma and enhancing user satisfaction—underscore the potential of peer support as a transformative tool across diverse healthcare systems. These insights can inform international policy dialogues, particularly in countries with similar goals of deinstitutionalization and recovery orientation, while also contributing to global efforts to embed experiential knowledge in mental health care planning, delivery, and evaluation.

Limitations

This study has several limitations. First, although the response rate (45%) is acceptable for a national survey, it limits the generalizability of the findings. Nevertheless, data on residents indicate that, despite this response rate at the MHD level, the sample covers more than half of the national population (51.7%), with good coverage in the North (64.9%), moderate in the Centre (48.5%), and lower in the South/Islands (38.7%). At the regional level, coverage exceeded 60% in several northern regions (e.g., Veneto, Trentino-Alto Adige, Piedmont, Lombardy), whereas Friuli Venezia Giulia, Marche, Sardinia, and Basilicata were notably under-represented. These patterns suggest potential non-response bias if practices or contexts in under-represented regions differ systematically from those in areas with higher participation. Second, participating MHDs tended to serve larger catchment areas than non-respondents, potentially introducing an upward bias for indicators correlated with service scale (e.g., availability of specialised teams, structured peer roles). Conversely, since all MHDs are publicly funded and operate within the same national policy framework, we found no evidence of systematic differences in funding model or organisational type that would independently account for the main findings. Third, the data were self-reported by MHD directors or their delegates, raising the possibility of social desirability bias or discrepancies between reported practices and actual implementation. Fourth, the cross-sectional design precludes any assessment of the impact or longitudinal evolution of peer support initiatives over time. Fifth, the study did not include the perspectives of peer support workers themselves, nor those of service users or frontline professionals, which would be essential for a more comprehensive and nuanced understanding of the facilitators and barriers to implementation. Sixth, while the questionnaire was developed in collaboration with

experienced PSWs and subjected to internal review, it was not validated through a formal psychometric process. Finally, given the regional variability of Italy's decentralized mental health system, the survey may not fully capture the diversity of local practices and innovations.

Conclusions

This study provides the first national overview of peer support and co-production practices in Italian mental health services. While peer support is gaining visibility and recognition, its integration remains partial, underfunded, and inconsistently structured. Co-production, though emerging, often falls short of meaningful user involvement in decision-making. To ensure the sustainability and effectiveness of these practices, national and regional authorities must invest in formal frameworks, resource allocation, and cultural transformation. Italy's experience—rooted in a rights-based, community-oriented model—offers valuable lessons for other countries aiming to embed lived experience in mental health policy, service design, and care delivery.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-13407-z.

Supplementary Material 1

Supplementary Material 2

Supplementary Material 3

Supplementary Material 4

Supplementary Material 5

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Author contributions

AL and CB conceived the study. AL and CB designed the questionnaire and collected the data. CB analyzed the data. AL drafted the first version of the manuscript. All authors contributed to the interpretation of the findings, critically revised the manuscript, and approved the final version.

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Data availability

The datasets generated and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Declarations

Ethical approval and consent to participate

This study did not require formal ethics approval, as it did not involve the collection of patient data, sensitive information, or any information allowing the identification of individuals. Only anonymous and objective information on organizational practices was collected from the Directors of the participating Departments of Mental Health. In accordance with Italian data protection legislation (Legislative Decree No. 196/2003, "Data Protection Code," as amended by Legislative Decree No. 101/2018), research of this nature does not require submission to or approval by an ethics committee or institutional review board. As the study did not constitute biomedical research on human subjects, adherence to the Declaration of Helsinki was not applicable. Similarly, no formal written informed consent was required.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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